MEMBER ENROLLMENT FORM

Please Print Information

Name: _____ Gender: Male ☐ Female ☐

Street Address: _____

City, State, Zip: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ Birthday: ____/____/____

Marital Status: _____ Spouse's Name: _____

Wedding Anniversary: _____ Housemate: _____

Veteran: ☐ Yes ☐ No Branch: _____

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Other

Ethnicity: Hispanic ☐ Yes ☐ No

How did you hear about the center?_____

If a current BSBAC member referred you to us, please share their name with us so we can thank them!

Referred by:_____

Our center has a variety of volunteer opportunities including Meals on Wheels, office assistance, grounds keeping, etc.

☐ Yes, I would like to receive a Volunteer Information Packet.

Emergency Contacts

In the event you are unable to communicate in an emergency, we will contact 911 immediately.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

In the event you are unable to communicate in an emergency, are there any medical conditions that you would like us to be able to share with an emergency medical provider? _____

_____

Releases

The Bulverde Spring Branch Activity Center produces a member directory yearly for its members. Do you authorize your contact information to be listed in this publication? **Yes** **No**

The Bulverde Spring Branch Activity Center uses social media such as their website, Facebook and electronic newsletters to keep members/public informed about the activities and events going on at the center. Do you authorize the Bulverde Spring Branch Activity Center the right to use your photograph or image for these purposes? **Yes** **No**

The information provided on this form will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet your needs.

Medical & Health Information – *Voluntary*

Information you would like us to have on file in the event of an emergency

Physician: _____ Office Phone: _____

Preferred Hospital: _____ Phone: _____

Release of Liability

I certify that I am participating in Programs and Activities sponsored at or by the Bulverde Spring Branch Activity Center voluntarily, with or without the consent of my health care specialist.

The scheduled programs and activities, including the exercise and fitness center classes, have been explained to me, and I fully understand what is involved in participation.

In signing below, I assume risk of harm or injury which may occur to the participant as a result of participating in Bulverde Spring Branch Activity Center activities. I hereby release Bulverde Spring Branch Activity Center and its officers, employees, or agents from any liability, costs and damages resulting from my participation in the various programs.

I further certify that I have read the foregoing document, I understand and agree to its terms and conditions and that I make this application and waiver voluntarily.

SIGNED, this_____ day of _____, 2021.

_____

Member Signature

_____

Printed Name

If you fall and are unable to get up on your own accord, 911 will be called and an ambulance will be requested. The Bulverde Spring Branch Activity Center staff will not life you or allow others to life you. This is for your safety and the safety of others. We do not know what type of injuries that have been sustained and we do not want to take any chances of injuring you further. The Bulverde Spring Branch Activity Center is not responsible for payment of EMS service. If you fall or are injured and are able to get up and seem fine, the Bulverde Spring Branch Activity Center requests that you let us take you to your physician or the Emergency Room to assure that there are no underlying injuries. An accident/incident report will be filed, and you will be required to sign if possible.

If 911 is called, we will contact the persons listed as emergency contacts and make them aware of the situation. For your peace of mind please make sure that you have arranged for Medical Power of Attorney (available at the hospital) and that you have listed contacts that have knowledge of your medical history, are nearby or have the information to contact your next of kin. Keep in touch with your family and update them on any changes you make such as, change in physicians, etc.

_____ _____

Client Signature Date

*For office use **only:***

☐ **Tivity Health SilverSneakers®**

☐ **Optum® Fitness Advantage / Renew Active**

☐ **Silver&Fit®**

☐ **Tivity Health Prime®**

☐ **Optum® At Your Best / AARP® Medicare Supplement**

Paid (if applicable): $_____

Health Plan ID: _____

Payment Date:	*Payment Amount:*
Entered into SS:	*Payment Note:*
Entered into CC:	*Scan Card Number:*
Enrolled into Insurance:	*Insurance Info. in SS:*
Database Photo:	*MEF Scanned to record:*

For Office Use Only